PLAN DOCUMENT,
SUMMARY PLAN DESCRIPTION
AND
ADMINISTRATIVE INFORMATION

HANFORD EMPLOYEE
WELFARE BENEFIT PLANS

Offered under the
HANFORD EMPLOYEE
WELFARE TRUST (HEWT)

DATED JANUARY 1, 2003

This Plan document and Summary Plan Description contains information the Plan Administrator is required to provide to you under federal law.

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HIGHLIGHTS

This document (sometimes herein referred to as "Booklet") is the formal plan document and summary plan description under which the welfare benefit plans (the "Plans") listed in Attachment A (the "Plans Chart") and offered under the Hanford Employee Welfare Trust (the "Trust") are administered. This document governs benefits provided to active employees and their dependents. A separate document governs benefits provided to retirees and their dependents. As used in this document, "we," "us" and "our" refers to the Plan Administrator. "You" and "your" are referring to covered employees and their dependents.

You should read this document as it contains important information about your rights and obligations under federal law and under the Plans and the procedures you need to follow if you have questions about your benefits or if you disagree with a decision on your claim for benefits.

Benefits under the Plans are provided through the Trust. The Trust has been adopted by the employers listed on Attachment B (the "Sponsors Chart"). They are the Sponsors of the Plans. You are receiving this Booklet because your employer is one of the Sponsors of the Plans.

The Sponsors have appointed the Board of Trustees of the Trust as the Plan Administrator of the Plans. Fluor Hanford, Inc. ("Fluor") has responsibility under their Contract with the United States Department of Energy (the "DOE") for administering the Plans. The Board of Trustees has delegated certain administrative responsibilities to Fluor. Other entities are involved in the insurance and/or administration of the Plans as well. These are described in the Plans Chart.

You have received additional summaries or summary plan descriptions ("SPDs") governing the Plans in which you are eligible to participate either electronically or in writing, and if you received them electronically you are entitled on request to receive printed copies. Contact Joel Sorensen, Benefits Administration, at (509) 376-1524. The SPDs provide detailed information about the benefits you are entitled to and steps you must take to obtain those benefits. The SPDs are incorporated herein by this reference. If there are conflicts between the language of the SPDs and this document, the terms of this document control. You may also receive official additional plan documents, insurance contracts, trust agreements and other documents which legally govern the operation of the Plans (the "Plan Documents"). This Booklet is intended to be read in conjunction with and as a supplement to the SPDs and other Plan Documents, except as otherwise expressly provided.

DESCRIPTION OF THE PLANS

The names of the Plans (and, if different, the name by which the Plans are commonly known), Plan number assigned by the Board of Trustees, and the types of the Plans (medical, dental, life, disability, etc.) are described in the Plans Chart.

PLAN SPONSORS

The names of the Sponsors, their addresses and their Employer Identification Numbers ("EINs") assigned by the Internal Revenue Service are described in the Sponsors Chart. In addition,

participants and beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular employer is a Sponsor of the Plan and, if the employer is a Plan Sponsor, the Sponsor's address.

EMPLOYER IDENTIFICATION NUMBER AND PLAN IDENTIFICATION NUMBER

The Employer Identification Number assigned to the Trust by the Internal Revenue Service is 91-2017261. The Plan Identification Number is 550.

PLAN TRUSTEES

The name, title and address of the principal place of business of the trustees of the Plans is:

Board of Trustees of the Hanford Employee Welfare Trust
c/o Fluor Hanford, Inc.
P. O. Box 1000, MSIN: H3-08
Richland, WA 99352

PLAN ADMINISTRATOR

The designated Plan Administrator of the Plans is the Board of Trustees of the Trust. The rights, duties, powers, and authority of the Board of Trustees is described in the Hanford Employee Welfare Trust Agreement (the "Trust Agreement"). All of the Trustees are representatives of the Sponsors (including your Employer) who establish and maintain the Plans.

The name, address and telephone number of the Plan Administrator is:

Board of Trustees of the Hanford Employee Welfare Trust
c/o Fluor Hanford, Inc.
P.O. Box 1000, MSIN: H3-08
Richland, WA 99352
Attn: Michael Hradec, Manager of Benefits Accounting
Telephone: (509) 372-3323

PLAN ADMINISTRATOR'S DISCRETION

In carrying out its responsibilities under the Plans, the Plan Administrator has the exclusive responsibility and full discretionary authority to control the operation and administration of the Plans and to make all fiduciary decisions under the Plans, and it has all power necessary to accomplish such purposes. These powers include, but are not limited to:

- To make and enforce such rules and regulations as in its sole and absolute and uncontrolled discretion it deems necessary or proper for the efficient administration of the Plans which are not inconsistent with the terms of the Plans or ERISA.

- To interpret the Plan documents in its discretion and its interpretation in good faith. Such interpretation is final and conclusive on all persons claiming benefits under the Plans.

- To use, employ, discharge or consult with one or more individuals, corporations or other entities with respect to advice regarding any responsibility, obligation or duty in connection with the Plan.

- To allocate fiduciary responsibilities by written instrument signed in the same manner as provided for delegations.

- To designate other individuals, corporations or other entities to carry out fiduciary responsibilities, obligations and duties under the Plan, and to revoke, modify or change any such delegation, revocation or modification by written instrument.

In carrying out its responsibilities, the Plan Administrator shall be fully protected to the fullest extent permitted under ERISA. In the event of any delegation in accordance with the above, no fiduciary shall be liable for any act or action, whether of commission or omission, taken by the person to whom the delegation is made. Fiduciary responsibilities shall be exercised severally and not jointly and each fiduciary's powers, duties, obligations and responsibilities shall be limited to those specifically allocated to such fiduciary or in accordance with the terms of this Booklet.

PLAN RECORDS AND PLAN YEAR

The fiscal records for all Plans are maintained and reported on a twelve-month period of time, known as the Plan Year. The Plan Year begins on January 1 and ends on December 31.

SOURCE AND AMOUNT OF CONTRIBUTIONS

The source of contributions for each Plan is described in the Plans Chart. Depending on the Plan, contributions are made entirely by the Sponsors, entirely by the participants, or partly by the Sponsors and partly by the participants. The Board of Trustees will determine, from time to time, what portion of the benefits will be paid directly by the Sponsors and what portion will be paid by the participants. Any amounts paid by a Sponsor will be paid out of such Sponsor's general assets. Currently, the employee participants' share of the costs, if any, for the medical and dental plans are reflected on Attachment C (the "Employee Contributions Chart"). The participants' share of the costs, if any, for the other Plans will be reflected on the applicable enrollment forms.

PAYMENT OF BENEFITS

How benefits are paid under each Plan (i.e., the method of payment of benefits) is described for each Plan in the Plans Chart. The Chart provides the name of any insurance company, trust fund or other institution, organization, or entity which maintains a fund on behalf of a Plan or through which a Plan is funded or benefits are provided.

You should read the Plans Chart to understand exactly how benefits are paid for each Plan in which you participate. However, the following provides some general background.

The primary function of the Trust is to receive and hold Sponsor and participant contributions to the Plans, to pay insurance premiums or claims under the Plans and Plan expenses, as applicable. However, the Trust is not solely responsible for payment of benefits under the Plans. Benefits are payable by the insurance company, the Sponsors (i.e., your Employer) or a combination of both, depending on whether the Plan is insured, self-insured or partly insured and partly self-insured.

Some of the Plans under which your benefits are provided are insured, as described on the Plans Chart (the "Insured Plans"). This means that only the insurance company which insures those benefits is responsible for payment of those benefits. Your Employer is not responsible for payment of any benefits under the Insured Plans.

Some of the Plans under which your benefits are provided are self-insured by the Sponsors, as described on the Plans Chart (the "Self-Insured Plans"). **This means that only your Employer is responsible for payment of those benefits.** Sponsors other than your Employer are not responsible for payment of your benefits under the Self-Insured Plans.

Although Fluor may administer aspects of a Plan, it only has responsibility for payment of your benefits if Fluor is your Employer and the Plan is Self-Insured by Fluor.

DESCRIPTION OF BENEFITS

A description or summary of the benefits for each Plan is contained in a separate SPD for each Plan. The SPD may also make reference to schedules of benefits these are available without cost to any participant or beneficiary who so requests.

ELIGIBILITY AND DISQUALIFICATION FOR BENEFITS

You are eligible to participate in the applicable Plans described in the Plans Chart if you are an "active" employee. You are an "active" employee if you are a regular full-time or part-time employee of one of the Sponsors, and are working a minimum of 20 hours per week. There may be differences in coverage and contributions between actives based on their status as non-union or union represented and these differences are described in the Plans Chart. Temporary and hourly employees are not eligible.

Notwithstanding the foregoing, a Sponsor in its adoption agreement may limit eligibility to less than all employees and dependents. In that event, you will be notified. The effective date of your coverage is the date of acceptance of enrollment by the Plan Administrator. There is no waiting period for coverage. To obtain coverage, you must enroll within the 30-day period immediately following date of employment in an eligible class. Your dependents must be enrolled within the same time period. If you or your dependents are not enrolled when first eligible, you will be required to wait until the next open enrollment period to elect coverage unless a special enrollment right is available to you. An open enrollment period will be offered

annually at such dates as the Plan Administrator shall determine. Special enrollment rights are available to you under the Health Plans offered by the Trust as required by federal law. See page 26.

Health and Dental Plans

Your dependents, as defined below, are eligible to participate only as described in the Plans Chart. All dependents must also meet the requirements set forth below applicable to the type of dependent. A dependent may not be enrolled in a Plan unless you are enrolled in the Plan.

Eligible dependents include:

- Your legal **spouse**, unless he or she is enrolled in one of the Plans as an employee or retiree.
- An **unmarried child or children** who is or are:
  - your natural child or the natural child of your legal spouse;
  - under the age of 23;
  - 23 or more years old, coverage can be continued if the child is
    - not regularly employed on a full-time basis, and
    - primarily dependent upon you for support and maintenance, and
    - a full-time student,
      - A full-time student is a person who is enrolled in and attending, full-time, a recognized course of study or training at one of the following:
        - an accredited high school,
        - an accredited college or university,
        - a licensed vocational school, technical school, beautician school, automotive school, or similar training school.

      Full-time student status is determined in accordance with the standards set forth by the educational institution. Full-time student status ceases upon graduation or if you are no longer enrolled and attending on a full-time basis. Full-time student status continues during periods of regular vacation.
  - Or, the child is 23 or more years old and not able to be self-supporting by reason of mental retardation or a physical handicap, provided

- the handicap existed before age 23, and
- the child was covered as a dependent prior to reaching age 23, and
- the child is mainly dependent on you for support, and
- proof of the child's condition and dependence is submitted within 31 days of the date coverage would otherwise have ended.

We may require that the child be examined by a physician chosen by us at our cost. You may be required to continue to provide proof that the child meets the conditions of incapacity and dependency. If you do not provide proof of the child's incapacity and dependency within 30 days of request, coverage for the child will end.

A child will cease to be a Dependent upon marriage or enlistment in the military service.

The term "child" means:

- A natural child,
- A stepchild,
- A legally adopted child,
- A child placed for adoption,
- A child for whom legal guardianship has been awarded to you or your spouse,
- Any other children permanently residing in your household who are principally dependent upon you for maintenance and support ("Special Dependents").

Approval of "Special Dependent" status from the insurance company is required to cover children in this category. "Special Dependents" currently approved must be periodically reviewed for continued coverage. Contact Benefits Administration via e-mail at *Benefits – PHMC or plant mail at H2-23 for more information if you have dependents in this category.

Your dependents are covered from the date they join your family by reason of birth, legal adoption, placement for adoption, or marriage. However, you must formally add them as covered dependents within 31 days of the event to ensure continued coverage.

If both you and your spouse are employees of a Sponsor, each of you can enroll in a Plan as an employee, or one spouse can enroll as an employee and cover the other spouse as a dependent. Except where specifically authorized by prior agreement, coordination of benefits between any of the Company sponsored plans will not apply.

If both you and your spouse are covered under the Plan as employees, your children may be enrolled as dependents on one of your Plans, but not both. A child cannot be covered as a

dependent if that child is eligible for coverage as an employee under any Sponsor's group medical plan.

No individual who is characterized by the Sponsor as an independent contractor (regardless of how that individual is classified under applicable state or federal law) is eligible. Participation in any of the Plans should not be viewed as a contract of employment.

Dependent Life Insurance and Personal Accident Insurance

For dependents eligibility rules, see Attachment A to this booklet, and the definition of dependent in the applicable Summary Plan Description (SPD).

ELIGIBILITY FOR RETIREE BENEFITS

If you are a covered employee, you and your dependents may be eligible for retiree benefits when you retire from active employment with all Sponsors. For a discussion of the eligibility requirements for retiree benefits, see the Plan Document, Summary Plan Description and Administrative Information, Hanford Retiree Welfare Benefit Plans.

DISQUALIFICATION FOR BENEFITS

Your eligibility to participate in the applicable Plans will end:

- In accordance with the terms of the applicable SPD,
- When the Plan is discontinued or terminated,
- When you fail to make any required contribution,
- For an enrolled dependent, when he or she no longer meets the requirements to remain an eligible dependent.

Additional circumstances which may result in disqualification, ineligibility or denial, loss, forfeiture or suspension of any benefits are described in Attachment D (the "Changes in Eligibility Chart").

TYPE OF PLAN ADMINISTRATION

The type of administration (contract administration, insurer administration, etc.) of each Plan is described in the Plans Chart.

NAME AND ADDRESS OF AGENT FOR LEGAL PROCESS

The name and address of the agent for service of legal process for the Plans is:

Mr. Ralph Hawkins
Davis Wright Tremaine LLP
2600 Century Square
1501 Fourth Avenue
Seattle, WA 98101-4552

Legal process may also be served upon a Plan Trustee or the Plan Administrator.

PLAN DOCUMENTS

The Plan documents consist of this document, the summary plan descriptions, certificates of insurance, group insurance contracts, the Trust Agreement and the formal interpretations adopted by the Plan Administrator. Upon written request to the Plan Administrator, copies of any or all of the Plan documents will be furnished to a Plan participant or beneficiary at a nominal charge.

AMENDMENT AND TERMINATION OF THE PLANS

The Trust and the Sponsors have established the Plans with the bona fide intention and expectation that they will be continued indefinitely, but they reserve the right to terminate all or any of the Plans, in whole or in part, at any time, without liability. This includes, without limitation, the right to increase or decrease the Sponsors' contributions or the participants' contributions to all or any of the Plans, at any time, and to modify all or any part of the coverage with respect to any or all of the participants covered by a Plan or Plans. Any termination will be in accordance with the provisions of the Trust and the agreements under which the Sponsors adopted the Plans (the "Adoption Agreements"). Any amendment, modification or termination will be approved by the Trust and the Sponsors, as applicable, in accordance with the Trust Agreement, the Adoption Agreements, and the normal procedures of the Trust and the Sponsors for transacting business.

Upon termination or discontinuance of any Plan, you will not have any further rights, other than for the payment of benefits for covered losses or expenses incurred before such Plan was terminated. The amount and form of any final benefit you or your beneficiary receive will depend on the Plan Documents and the Plan Administrator's decisions.

CLAIMING BENEFITS

You or your beneficiary must file the appropriate forms to receive any benefits or to take any other action under any of the Plans, as described in the applicable SPD or certificate of insurance. Completed forms should be submitted to the appropriate entity described in the applicable SPD or certificate of insurance. Generally, you or your provider on your behalf will initiate a claim for benefits with the applicable party administering the benefit plan (the claims administrator or insurance company). Please review the SPD or certificate of insurance to determine exactly how to initiate a claim for benefits.

You must exhaust all of the claims review procedures described in the applicable SPD or certificate of insurance before you are entitled to initiate a lawsuit in state or federal court. If

there are no claim and/or review procedures set forth in the SPD or certificate of insurance, you may follow the procedure set forth below. In some instances, after you have exhausted your claim and appeal rights before the claims administrator or insurance company, you may be entitled to a final appeal to the Plan Administrator. Consult the applicable SPD or certificate of insurance.

APPEALING A DENIED CLAIM

Health Benefits

Urgent Claims

If your appeal involves an urgent claim that requires immediate action, all levels of appeal have been delegated to the claims administrator or insurance company that is responsible for paying claims. The claims administrator or insurance company's decisions are conclusive and binding. Consult the applicable SPD.

Non-Urgent Claims – Insured Health Benefits

If your appeal involves a non-urgent claim and you are participating in an insured group health plan (currently Group Health, Options and Willamette Dental), all levels of appeal have been delegated to the insurance company that is responsible for paying claims. The insurance company's decisions are conclusive and binding. Consult the applicable SPD.

Non-Urgent Claims – Self-Insured Health Plan

With respect to pre-service and post-service claims that are non-urgent claims under the self-insured health plans currently administered by United Healthcare and CIGNA (Dental), if you are not satisfied with the first level appeal decision of the claims administrator, you have the right to request a second level appeal to the Plan Administrator. Your second level appeal request must be submitted to the Plan Administrator within 60 days from the receipt of the first level appeal decision, or, if later, within 180 days following the initial adverse benefit determination. You will be provided the following:

- The opportunity to submit written comments, documents, records and other information relating to your appeal.
- To receive upon request and free of charge reasonable access to, and copies of, all documents, records and other information relevant to your appeal.
- A review that takes into account all comments, documents, records and other information submitted by you relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.
- A review which will be conducted by the Plan Administrator that does not afford deference to the initial adverse benefit determination.

- If the appeal is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the Plan Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

- The Plan Administrator will identify all medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination without regard to whether the advice was relied upon.

- Any health care professional engaged for purposes of a consultation with respect to your appeal will be an individual who is neither an individual who was consulted in connection with the initial adverse benefit determination nor a subordinate of such individual.

You will receive notification of the Plan Administrator's decision on your appeal not later than 30 days after receipt by the Plan Administrator of your request for review unless the Plan Administrator determines that special circumstances (such as the need to hold a hearing) require an extension of time, in which you will be notified prior to the termination of the initial review period. Notice shall be provided to you in writing or electronically.

In the case of an adverse decision on your request for review, the notice shall:

- Specify the reason or reasons for the adverse determination.

- Provide you reference to the specific Plan provisions on which the determination is based.

- Provide you with a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the review.

In the event that you are not satisfied with the disposition of your appeal, you are entitled to initiate a lawsuit under Section 502(a) of the Employee Retirement Income Security Act.

Pharmacy Benefit Program

If you are not satisfied with the disposition of your claim for benefits under the Pharmacy Benefit Program as administered by Express Scripts, you have the right to one appeal to the Plan Administrator. Follow the procedure above under the heading Non-Urgent Claims.

Disability Benefits

Filing a Claim

- **First 35 Days**

To receive disability benefits under the Hanford Employee Welfare Trust Disability Plan, you must file a claim for benefits. The claim must be filed with your Employer or your Employer's Benefits Administrator. Contact your Employer's Benefits Administration Department for the proper form. The form must be completed by your attending physician in order to qualify you for benefits. Benefits will normally be paid for as many as the first 35 days of disability based upon the properly completed form. However, your Employer reserves the right to request additional information from your attending physician to confirm your disability status. If your claim for benefits during the first 35 days of disability is denied, follow the appeal procedure set forth below.

- **Through 180 Days**

If your disability continues beyond 35 days, you must file a claim with CIGNA. It is recommended you contact CIGNA Intake at 1-800-362-4462 in advance of the end of the first 35 days of your disability to minimize process delay. CIGNA will require additional supporting medical information from your attending physician and completion of its internal review process as a condition to the continuation of benefits beyond the 35th day of disability. If your claim for benefits beyond the 35th day of disability is denied, follow the appeal procedure set forth below.

- **Long Term**

If your disability extends beyond 180 days, continuation of your benefits is dependent upon your qualifying for long-term disability benefits. You must provide written proof of disability to CIGNA no later than 90 days after the end of the 180-day short-term disability period. To initiate a claim, contact CIGNA, Long-Term Disability, at 1-800-238-2125, ext. 3067, as soon as you have reason to believe that your disability will exceed 180 days. You will be provided appropriate claim forms. If your claim for benefits is denied, follow the appeal procedure below.

Denial of a Claim

If your claim for benefits is denied, you will be notified in writing not later than 45 days after receipt of your claim by the Plan. This period may be extended for up to 30 days if necessary due to matters beyond control of the Plan in which case you will be notified in writing prior to the expiration of the initial 45-day period. An additional 30-day extension may be required if the decision cannot be rendered within the first 30-day extension period, but in that case you will be notified in writing of the circumstances requiring the additional extension and the date as of which the Plan expects to render a decision.

If your claim is denied, you will be provided in writing:

- The specific reason or reasons for the denial;

- Reference to the specific Plan provisions on which the determination is based;
- A description of any additional material or information required of you and why it is necessary;
- A description of the Plan's review procedures and time limits applicable to those procedures.

If you disagree with the denial of your claim, you may appeal the Plan's decision. Follow the applicable appeal process.

Appeal of Denied Claim

If you disagree with the denial of your claim, you should contact the appropriate claims administrator in writing to formally request an appeal. You must file your appeal within 180 days following receipt of the denial of your claim. If you do not file your appeal within that time, you will have waived your right to appeal. You must exhaust your appeal rights before you are entitled to bring an action in court.

- **First 35 Days of Disability**

If your appeal involves a denial of benefits during the first 35 days of your disability, your written appeal should be filed with your Employer. The notice of denial will specify the precise address to which the appeal should be sent.

- **Days 36 Through 180**

If your appeal involves the denial of benefits during days 36 through 180, your written appeal should be addressed to CIGNA. The notice of denial will specify the precise address to which the appeal must be sent.

- **Long-Term Disability**

If your appeal involves the denial of long-term disability benefits, your written appeal should be addressed to CIGNA. The notice of denial will specify the precise address to which the appeal must be sent.

Appeal Process First 35 Days of Disability

Your appeal will be administered by a fiduciary of the Plan who is neither the individual who made the initial determination denying your claim nor a subordinate of such individual. The fiduciary who administers your appeal will not give deference to the decision of the individual who made the initial decision. You will have the following rights:

- The opportunity to submit written comments, documents, records and other information relating to your claim.

- You will be provided upon request and free of charge reasonable access to and copies of all documents, records and other information relevant to your claim.

- You will be entitled to a review that takes into account all comments, documents, records and other information submitted by you without regard to whether the information was submitted or considered in the initial decision on your claim.

If the initial decision denying your claim is based in whole or in part on a medical judgment, the fiduciary administering your appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The person consulted by the fiduciary administering your appeal will be a person other than an individual consulted in the initial decision on your claim and will not be a subordinate of such individual. Any expert whose advice was obtained on behalf of the Plan will be identified to you without regard to whether his advice is relied upon.

You will be notified of the result of the appeal of your claim not later than 45 days after it is received unless the Plan determines that special circumstances (such as the need to hold a hearing) require an extension of time. If an extension of time is required, you will receive written notice prior to the expiration of the initial 45-day period. In no event shall the extension exceed a period of 45 days from the end of the initial period. The written notice provided to you will indicate the special circumstances requiring the extension and the time and the date by which the Plan expects to reach a decision on your appeal.

You will be notified in writing of the Plan's decision on your appeal. The decision of your Employer or your Employer's claims administrator is final. If the Plan denies your appeal, the notice will set forth the following:

1. The specific reason or reasons for the denial.

2. Reference to the specific Plan provisions on which the denial is based.

3. A statement that you are entitled to receive upon request and free of charge reasonable access to, and copies of, all documents, records and other information relevant to your claim.

4. A statement of your right to bring an action under Section 502(a) of the Act.

Appeal Days 36 Through 180 and Long-Term Disability Claims

If your claim for disability benefits days 36 through 180 or for long-term disability benefits is denied, you are entitled to appeal to the claims administrator (currently CIGNA). You must exhaust your appeal rights before bringing an action in court. You must address your request for appeal to CIGNA at the address specified in the denial notice. You must file your written request for appeal to CIGNA within 180 days from the date you receive the denial. If you do not make this request within that time, you will have waived your right to appeal.

Once your request has been received by CIGNA, a prompt and complete review of your claim must take place. This review will give no deference to the original claim decision, and will not

be made by the person who made the initial claim decision. During the review, you (or you duly authorized representative) have the right to review any documents that have a bearing on the claim, including the documents which establish and control the Plan. Any medical or vocational experts consulted by CIGNA will be identified. You may also submit issues and comments that you feel might affect the outcome of the review.

CIGNA has 45 days from the date it receives your written request to review your claim and notify you of its decision. Under special circumstances, CIGNA may require more time to review your claim. If this should happen, CIGNA must notify you, in writing, that its review period has been extended for an additional 45 days. Once its review is complete, CIGNA must notify you, in writing, of the results of the review and will set forth the following:

1. The specific reason or reasons for the denial.

2. Reference to the specific Plan provisions on which the denial is based.

3. A statement that you are entitled to receive upon request and free of charge reasonable access to, and copies of, all documents, records and other information relevant to your claim.

4. A statement of your right to bring an action under Section 502(a) of the Act.

All Other Benefits

The following text generally applies to life insurance benefits provided under the Plan and/or any other insured benefits. Before you are entitled to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act, you must exhaust all of the claims review procedures described in the applicable SPD or certificate of insurance. All levels of appeal have been delegated to the insurance company that is responsible for paying claims. The insurance company's decisions are conclusive and binding. You are not entitled to appeal the decision of the insurance company to the Plan Administrator.

RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 ("ERISA")

As a participant in the Plans, you are entitled to certain rights and protections under ERISA.

ERISA provides that all Plan participants are entitled to:

- Examine without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan Documents, including insurance contracts, collective bargaining agreements, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefit Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Publications Hotline of the Pension and Welfare Benefit Administration.

SPECIAL PROVISIONS APPLICABLE TO GROUP HEALTH PLANS

The following provisions apply only to Plans that are group health plans (each of which is a "Health Plan"), and shall supersede any inconsistent provisions in the Summary Plan Descriptions for Health Plans.

Qualified Medical Child Support Order

If a Health Plan receives a qualified medical child support order recognizing the right of any child of a participant to enrollment under the Health Plan, such child shall be enrolled as required under the terms of the order. Qualified medical child support orders shall be administered in

accordance with procedures adopted by the Plan Administrator. You may obtain without charge a copy of such procedures from the Plan Administrator.

Family and Medical Leave

If a Participant is on an unpaid leave to care for a newborn; to care for a child placed with the Participant for adoption or foster care; or for a serious health condition of the Participant or the Participant's spouse, child or parent, coverage for the Participant and eligible Dependents will be continued for up to twelve (12) weeks. The Employer will continue to pay for coverage to the extent required by law. To maintain eligibility, the employee must continue to contribute the same share of cost of coverage that he or she would pay when not on leave.

Military Leave

Employees going into or returning from military service may elect to continue Health Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). These rights apply only to eligible employees and eligible dependents covered under the Health Plan before leaving for military service.

The maximum period of coverage of a person under such an election shall be the lesser of:

- The 18 month period beginning on the date that Uniformed Service leave commences; or
- The period beginning on the date that Uniformed Service leave commences and ending on the day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

A person who elects to continue Health Plan coverage may be required to pay up to 102% of the full contribution under the Health Plan, except a person on active duty for 30 days or less cannot be required to pay more than the employee's share, if any, for the coverage. However, plan exclusions and waiting periods may be imposed for any sickness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

Layoff

If you are laid off as a result of a reduction of force, coverage for you and your dependents may be continued provided all required contributions are paid. During the first year, contributions are the same as required of an active employee. During the second year, you must pay 50% of the COBRA rate (see below). During the third year and thereafter, you must pay 100% of the COBRA rate. This period of coverage will be credited toward satisfying the maximum coverage provided under COBRA discussed below.

Approved Leave of Absence

If you are on an approved leave of absence (other than for military service), coverage for you and your dependents may be continued, provided all required contributions are paid.

Disability

If you become disabled and qualify for disability benefits under your Employer's short-term or long-term disability program (or state industrial insurance), coverage for you and your eligible dependents may be continued for the duration of the disability, until a dependent no longer qualifies as such or until you are eligible for normal retirement, whichever first occurs. You must pay all required contributions. This period of coverage will be credited toward satisfying the maximum coverage provided under COBRA discussed below.

Death

If you die, coverage for your eligible dependents will continue for a period of one year. Your required contributions are waived. If at the date of your death you have attained age 55 and have 10 or more years of service, your covered dependents may elect to continue coverage beyond one year. The election must be in writing and within 31 days after coverage would otherwise end. Coverage is dependent upon payment of required contributions. Coverage ends upon the earlier of failure to make the required contributions or remarriage of a spouse. The remarriage of a spouse does not render other dependents ineligible. Coverage for a dependent will end when the dependent no longer meets the eligibility criteria to qualify as a dependent. This period of coverage will be credited toward satisfying the maximum coverage provided under COBRA discussed below.

Strike

If you cease work because of a strike, lockout, suspension or other labor dispute, coverage may be continued for up to six (6) months. If coverage is available, it will end upon failure to make required contributions. Any period of coverage will be credited toward satisfying the maximum coverage provided under COBRA discussed below.

COBRA Continuation Coverage

Eligibility.

If you are an employee of the Employer and you are covered by the Health Plan, you have a right to elect COBRA continuation coverage if you lose your group health coverage under the Health Plan for any of the two following qualifying events:

- A reduction in your hours of employment; or
- The termination of your employment (for reasons other than gross misconduct).

If you are the spouse of an employee covered by the Health Plan, you have the right to elect COBRA continuation coverage for yourself if you lose your group health coverage under the Health Plan for any of the following four qualifying events:

- The death of your spouse;

- The termination of your spouse's employment (for reasons other than gross misconduct) or a reduction in your spouse's hours of employment;

- Divorce or legal separation from your spouse; or

- Your spouse becomes entitled to Medicare benefits under Title XVIII of the Social Security Act.

A dependent child of an employee covered by the Health Plan has the right to elect COBRA continuation coverage if the dependent child's group health coverage under the Health Plan is lost for any of the following five qualifying events:

- The death of the employee-parent;

- The termination of the employee-parent's employment (for reasons other than gross misconduct) or reduction in the employee-parent's hours of employment;

- The parents' divorce or legal separation;

- The employee-parent becomes entitled to Medicare benefits under Title XVIII of the Social Security Act; or

- The dependent ceases to be a "dependent child" under the Health Plan.

If a child is born or adopted by the covered employee during the period of COBRA continuation coverage, and the covered employee has elected COBRA continuation coverage, then the employee (or other guardian) may elect COBRA continuation coverage for the child.

Electing COBRA Continuation Coverage.

Under the law, the covered employee or a covered family member has the responsibility to inform the Plan Administrator of the employee's divorce or legal separation, or a child losing dependent status under the Health Plan. This notice must be given to the Plan Administrator within sixty (60) days after the later of (1) the date of such an event, or (2) the date on which the affected employee or family member would otherwise lose coverage because of such event. If this notice is not given to the Plan Administrator within the required 60-day period, the affected employee or family member will not be entitled to elect COBRA continuation coverage.

The Employer has the responsibility to notify the Plan Administrator of the employee's death, the employee's termination of employment or reduction in hours, or the employee becoming entitled to Medicare under Title XVIII of the Social Security Act.

When the Plan Administrator is notified that one of these qualifying events has occurred, the Plan Administrator will in turn notify the appropriate individuals (also called "qualified

beneficiaries") that they have the right to elect COBRA continuation coverage. COBRA continuation coverage must be elected by such individuals within sixty (60) days after the later of (1) the date that coverage under the Health Plan would otherwise terminate due to the qualifying event, or (2) the date that these individuals are provided with written notification of their right to elect COBRA continuation coverage. If COBRA continuation coverage is not elected within this 60-day period, the Health Plan coverage will end retroactive to the date that coverage would have otherwise ended due to the COBRA qualifying event, and the affected employee or family member will not be entitled to elect COBRA continuation coverage. While an election by a covered employee or covered spouse will be treated as an election of COBRA continuation coverage by the entire family, each family member may make a separate election as to COBRA continuation coverage. This means that a covered spouse or dependent child may elect COBRA continuation coverage even if the employee does not make that election. If a child is born to, or placed for adoption with, a covered former employee during the COBRA continuation coverage period and the covered employee has elected COBRA continuation coverage, then the employee may elect COBRA continuation coverage for that child provided that the covered former employee notifies the Plan Administrator within the Health Plan's normal enrollment window for newborn children, adopted children, or children placed for adoption. You (or your covered spouse or dependents) may elect COBRA continuation coverage even if you (or your covered spouse or dependents) are covered under another group health plan or are entitled to Medicare prior to electing COBRA continuation coverage.

Extent of Coverage.

If continuation of coverage is elected, the Employer is required to provide COBRA continuation coverage which, at the time that coverage is being provided, is identical to the coverage provided under the Health Plan to similarly situated Health Plan participants who have not experienced a qualifying event (called "non-COBRA beneficiaries"). For example, if an employee dies leaving a spouse and two dependent children covered under the Health Plan, they would be entitled to the same benefits as the covered spouse and dependent children of an active employee. If the benefits for similarly situated non-COBRA beneficiaries are modified, the changes will apply to those who have COBRA continuation coverage as well.

COBRA continuation coverage may be maintained for up to 36 months unless the group health coverage was lost due to the employee's termination of employment or a reduction in hours. In these two situations, COBRA continuation coverage may be maintained for up to 18 months. However, if the Social Security Administration determines that the covered employee, spouse or dependent child was disabled at any time during the first sixty (60) days of COBRA continuation coverage and such individual provides the Plan Administrator with a copy of that determination within sixty (60) days after it is made and before the 18-month period expires, then that 18-month coverage may be extended for an additional 11 months (for a total of 29 months after the date the COBRA continuation coverage began) for the disabled qualified beneficiary and other covered family members. In the case of a child born to, or placed for adoption with, a covered employee during the period of COBRA continuation coverage, the 60-day period (mentioned in the previous sentence) is measured from the child's date of birth or placement for adoption. Each covered employee or covered family member who is determined to be disabled (under Title II or XVI of the Social Security Act) at any time during the first 60 days of COBRA

continuation coverage has the responsibility to: (1) inform the Plan Administrator within sixty (60) days after the date of that determination, and (2) if applicable, inform the Plan Administrator within thirty (30) days after the date of any final determination that the covered employee or covered family member is not disabled.

Covered dependents who were covered by the Health Plan prior to the employee's termination of employment or reduction in hours and who are receiving COBRA continuation coverage, and any child born to the covered employee or placed with the covered employee for adoption and enrolled in the Health Plan while the covered employee is receiving COBRA continuation coverage, will be eligible to extend the initial 18-month COBRA continuation period (or if applicable, the 29-month COBRA continuation period) if one of the following events occurs during that 18-month period (or if applicable, the 29-month COBRA continuation period):

(1) the covered employee's death;
(2) the covered employee's divorce or legal separation;
(3) the covered employee becomes entitled to Medicare benefits; or
(4) a dependent child ceases to be a dependent under the terms of the Health Plan.

In any of the four situations described above, the covered dependents may extend their COBRA continuation coverage for up to 36 months from the date the covered employee terminated employment or lost Health Plan coverage because his or her hours were reduced. We ask that the covered employee or a covered family member inform the Plan Administrator of the employee's divorce or legal separation, or a child losing dependent status under the Health Plan within 60 days after the occurrence of such event. A family member whom the covered employee first enrolls during an open enrollment period or special enrollment period while the covered employee is receiving COBRA continuation coverage is <u>not</u> eligible to extend the COBRA continuation period as described in this paragraph, unless that family member is a child born to the covered employee or placed with the covered employee for adoption and enrolled in the Health Plan while the covered employee is receiving COBRA continuation coverage.

If a covered employee becomes entitled to Medicare while employed by the Employer, and within eighteen (18) months after the employee becomes entitled to Medicare, he or she loses group health plan coverage due to the employee's termination of employment or reduction in hours, then the employee's covered spouse and covered dependents may elect COBRA continuation coverage for a period beginning with that loss of coverage and ending 36 months after the date the employee became entitled to Medicare.

In general, you and your covered dependents (if any) will only be given an opportunity to continue the coverage you each were receiving immediately before the qualifying event. In a few circumstances, however, you may elect alternative coverage that the Employer makes available to active employees, such as:

(1) If you participate in a region-specific HMO that will not service your health needs in the area to which you are relocating, you must be given an opportunity to elect alternative coverage that the employer makes available to active employees.

(2) You and your covered dependents (if any) will have the same opportunity as an active employee to change your coverage at open enrollment, add new family members, or drop dependents.

(3) A qualified beneficiary who has elected COBRA continuation coverage may elect to cover certain family members under special enrollment rights if certain requirements are satisfied.

In general, there are special enrollment rights for certain family members upon the loss of other group health plan coverage or upon the acquisition by the employee or participant of a new spouse or of a new dependent through birth, adoption, or placement for adoption. Please refer to the Health Plan's summary plan description for further details on those special enrollment rights. Please note that a family member whom you first enroll during an open enrollment period or special enrollment period while you are receiving COBRA continuation coverage and who was not covered by the Health Plan on the day before the initial COBRA qualifying event occurred is not eligible to extend the initial COBRA continuation period as described in this notice, unless that family member is a child born to the covered employee or placed with the covered employee for adoption during the initial 18-month period of COBRA continuation coverage and enrolled in the Health Plan while the covered employee was receiving COBRA continuation coverage.

When COBRA Continuation Coverage Ends.

The law provides that COBRA continuation coverage will be cut short for any of the following reasons:

(1) the Employer no longer provides group health coverage to any of its employees;

(2) The premium for the COBRA continuation coverage is not paid on a timely basis (the first premium payment is payable in a lump sum forty-five (45) days after electing COBRA continuation coverage; all subsequent premium payments are payable within thirty (30) days after the due date);

(3) The covered individual first becomes, after the date of the COBRA continuation coverage election, covered under another group health plan (as an employee or otherwise) that does not contain any exclusion or limitation with respect to any pre-existing condition of that individual (other than an exclusion or limitation that does not apply to, or is satisfied by, such individual by reason of the Health Insurance Portability and Accountability Act of 1996);

(4) The covered individual first becomes, after the date of the COBRA continuation coverage election, entitled to Medicare (under Title XVIII of the Social Security Act);

(5) When coverage has been extended from 18 to 29 months, the Social Security Administration makes a final determination that an individual is no longer disabled (under Title II or XVI of the Social Security Act); or

(6) Upon the occurrence of any event (such as submission of fraudulent claims) by a covered individual that permits termination of Health Plan coverage for cause with respect to similarly situated non-COBRA beneficiaries.

In the case of the event listed in number (5) above, a disabled individual is required to inform the Plan Administrator within thirty (30) days after the date of any final determination that the covered employee or covered family member is not disabled. We ask that covered individuals notify the Plan Administrator if an event occurs that is listed in number (3) or (4) above within thirty (30) days after becoming eligible for such other group health plan coverage or entitled to Medicare.

Health FSA.

Under the Health Care Flexible Spending Account Plan (the "health FSA"), you may elect to pay for your uninsured medical expenses and the uninsured medical expenses of your spouse and dependents (if any) with before-tax dollars. Under applicable law, the health FSA need not make COBRA continuation coverage available to you or your covered spouse and dependents for any plan year after the plan year in which the qualifying event occurs if: (1) the health FSA is exempt from the Health Insurance Portability and Accountability Act of 1996, and (2) the maximum amount that the health FSA could require to be paid as a premium for a full plan year of COBRA continuation coverage equals or exceeds the maximum benefit available under the health FSA for the year. These two requirements are satisfied here. Thus, subject to the provision in the last sentence of this paragraph, you and your covered spouse and dependents are entitled to COBRA continuation coverage under the health FSA until the end of the plan year in which the qualifying event occurs. However, COBRA continuation coverage is not available at all under the health FSA if, as of the date of the qualifying event, the maximum benefit available to you or your covered spouse or dependents under the health FSA for the remainder of the plan year is not more than the maximum amount that the plan could require to be paid as a premium for the remainder of that year for COBRA continuation coverage (this would occur, for example, if you had "overspent" your health FSA account as of the date of the qualifying event).

Cost of Coverage.

The cost of COBRA continuation coverage will generally not exceed 102% of the cost to the Employer for coverage under the Health Plan. The cost of COBRA continuation coverage will increase in the middle of the 12-month determination period only in the following instances:

(1) where coverage extends beyond 18 months for a disabled individual, the cost of COBRA continuation coverage will be 150% of the applicable premium,

(2) where the qualified beneficiary changes to more expensive coverage, or

(3) where the Health Plan was previously requiring payment of less than the maximum permissible amount.

An individual seeking COBRA continuation coverage is liable for the cost of that coverage during the entire applicable 18-, 29-, or 36-month period (measured from the date that coverage would otherwise end due to the qualifying event). Due to the required sixty (60) day COBRA election period, it is likely that a covered individual will be responsible for retroactive premiums. These premiums must be paid in a lump sum within forty-five (45) days after electing COBRA continuation coverage in order for the COBRA continuation coverage to be effective. After that payment, premiums are due on a monthly basis. Coverage will terminate if premiums are not paid within thirty (30) days after the date they are due.

An individual need not show proof of insurability to elect COBRA continuation coverage.

Coverage Expires.

When COBRA continuation coverage expires after 18, 29 or 36 months, an individual may have the opportunity to enroll in an individual conversion health plan by the Health Plan provided such option is otherwise generally available to similarly situated non-COBRA beneficiaries under the group health plan.

Conversion Privilege

A conversion privilege may be available if at termination of your coverage under the Plan you are participating in an insured health plan such as a plan offered by an HMO. There is no conversion privilege offered under the uninsured medical plan provided by the Trust. If a conversion privilege exists, it will be described in the applicable SPD or certificate of insurance. Generally, if a conversion privilege is available, you may, within 31 days following termination of coverage, apply for an individual health insurance policy, and the policy will be issued to you without medical examination. The policy may also be available to any of your dependents covered under the Plan on the date coverage ends. The policy issued, if any, will be that which is offered by the particular insured plan at the time of application. Coverage will become effective the day after the day coverage under this Plan terminates. A conversion policy may also be available to your spouse upon the annulment or dissolution of your marriage, or your death, provided your spouse applies within 31 days after coverage terminates. For details with respect to the availability of a conversion policy, see the applicable SPD.

Benefits After Covered Mastectomy

After a covered mastectomy, the Health Plan will cover the medical and surgical benefits for the following:

1. All stages of reconstruction of the breast on which the mastectomy has been performed;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. Prostheses (implants, special bras, etc.) and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes) in a manner determined appropriate in consultation with the attending physician and the patient.

Coverage for breast reconstruction and related services will be subject to all applicable deductibles, copayments and coinsurance amounts that are consistent with those that apply to other benefits under the Health Plan.

The Health Plan will at all times comply with the terms of the Women's Health and Cancer Rights Act of 1998 and will not deny a patient eligibility, or continued eligibility to enroll or to renew coverage, under the terms of the Health Plan solely to avoid the requirements of this section. Additionally, the Health Plan will not penalize the patient or physician, or induce him or her to provide care to a participant in a manner inconsistent with this provision.

Any Health Plan exclusions or limitations that exclude the benefit described above are hereby omitted to the extent that they specifically prohibit the above coverage.

Mental Health Benefits

Benefits under a Health Plan shall be provided in compliance with the Mental Health Parity Act of 1998. The aggregate lifetime limit on benefits and/or annual dollar limit on benefits contained in the Summary Plan Descriptions shall apply both to medical and surgical benefits and to mental health benefits.

Newborns' and Mothers' Health Protection Act of 1996

For Insured Plans that provide maternity or newborn infant coverage, special rights upon childbirth under the Newborns' and Mothers' Health Protection Act of 1996, as amended, and state law, as applicable, are described in the SPDs for the applicable Insured Plan. For Self-Insured Plans that provide maternity or newborn infant coverage, special rights upon childbirth are described below:

Special Rights Upon Childbirth: Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

HIPAA provides certain limitations on preexisting condition exclusions and permits you to avoid the imposition of such exclusions by providing a certificate of creditable coverage. HIPAA also

prohibits discrimination against you based on your health status and provides you special enrollment rights. If you are unsure whether a particular plan is a Health Plan subject to HIPAA, please contact the Plan Administrator.

Preexisting Condition Limitations

There are no preexisting condition limitations in the Health Plans.

Certificate of Creditable Coverage

The Health Plan will provide a certificate of creditable coverage to participants and dependents covered under the Health Plan as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) at the following times:

- With respect to qualified beneficiaries who are entitled to elect COBRA continuation coverage, at the time they lose coverage under a plan in the absence of COBRA continuation coverage or alternative coverage.

- With respect to individuals who are not qualified beneficiaries under COBRA, at the time they cease to be covered under the plan.

- With respect to qualified beneficiaries who elect COBRA continuation coverage, at the time the individual's coverage ends under COBRA.

- Upon a participant's (or his or her spouse's or dependent's) request, if such request is made within 24 months after the individual loses coverage under the plan.

Creditable coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid or Medicare. However, the following are not "creditable coverage": accident-only plans, disability income plans, liability and limited-scope insurance, credit-only insurance, coverage for on-site medical clinics, coverage issued as supplemental to liability insurance automobile medical coverage, Workers' Compensation, and limited-scope dental or vision plans.

Nondiscrimination

Eligibility for benefits under the Health Plan will not be conditioned on any health status related factors such as health status, medical history, evidence of insurability, claims history, or genetic information. The Health Plan will not charge a contribution that is greater than the charge for a similarly situated individual based on any health status related factor. The Health Plan may offer premium discounts for a bona fide wellness program.

Special Enrollment Periods

Federal law requires Health Plans to provide "Special Enrollment Period" for certain individuals who previously refused coverage or individuals who became dependents through marriage, birth, adoption, or placement for adoption (as described further below). A person who enrolls during a special enrollment period is not considered a "late plan participant" for purposes of the Health Plan.

The Health Plan will provide a Special Enrollment Period for an employee or dependent who is eligible, but not enrolled in the Health Plan, if each of the following conditions is met:

- He or she is eligible, but not enrolled, for coverage under the terms of the Health Plan;

- He or she had other health plan coverage at the time coverage was previously offered;

- He or she states in writing when declining enrollment that the other coverage was the reason for declining enrollment (if required by the Plan Administrator at the time the individual previously declined enrollment);

- He or she loses coverage because (1) his or her COBRA continuation coverage expires, (2) the employee or dependent is no longer eligible for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, but not including as a result of failure to pay premiums on a timely basis or termination of coverage for cause); or (3) the employer ceases making contributions toward such coverage; and

- He or she requests a special enrollment right within thirty days after the exhaustion or termination of other coverage.

After an employee or dependent gives the completed request of enrollment to the Plan Administrator, his or her enrollment is effective no later than the first day of the next calendar month.

The Health Plan will also provide a Special Enrollment Period for an employee or dependent as follows:

- For an employee who is eligible but not enrolled in the Health Plan and declined coverage under the Health Plan during a prior Enrollment Period, (1) at the time of his or her marriage, and (2) at the time an individual becomes his or her dependent through marriage, birth, adoption, or placement for adoption;

- For a spouse of a participant (1) at the time of his or her marriage or (2) at the time an individual becomes a dependent of the participant through birth, adoption, or placement for adoption;

- For an individual who becomes a dependent of the participant through marriage, birth, adoption, or placement for adoption.

The Special Enrollment Period will extend for 30 days after the marriage, birth, adoption, or placement for adoption. For a Special Enrollment due to marriage, enrollment is effective no later than the first day of the month following the date the Employer receives the request for enrollment. For a special enrollment due to birth, adoption, or placement for adoption, enrollment is effective as of the date of the birth, adoption, or placement for adoption.

The enrollment date for anyone who enrolls under a Special Enrollment Period is the first date of coverage.

Attachment A

PLANS CHART

Plan Name, Number and Participants	Plan Type and Type of Administration	Sources of Contributions	Payment of Benefits
1. HEWT Options PPO Plan This Plan covers all actives. Dependents may be covered; see the Eligibility section. Plan No. 550	Health, vision, mental health and substance abuse, and prescription drug benefits. Contract Administration for health, mental health and substance abuse by United Healthcare Insurance Company. Contract Administration for Prescription drug benefit by Express Scripts. Contract Administration for vision by Spectera.	Sponsors Participants	Self-insured by your Employer (i.e. benefits are paid from employee contributions, if any, and the Employer's general assets) and are funded through the Hanford Employee Welfare Trust. United Healthcare Insurance Company provides administrative services only for health benefits, Express Scripts provides administrative services only for retail and mail order prescription drug benefits. Vision benefits are provided through Spectera. United Behavioral Health provides administrative services only for behavioral care. United Healthcare Insurance Company's administrative services include claim administration, cost

Plan Name, Number and Participants	Plan Type and Type of Administration	Sources of Contributions	Payment of Benefits
			containment, financial, banking and billing administration. All such services include payment of claims. These service providers do not insure any of the benefits. United Healthcare Insurance Company's address is: P.O. Box 30555 Salt Lake City, UT 84130-0555 Express Scripts' address is: Express Scripts P.O. Box 390873 Bloomington, MN 55439 Spectera's address is: Spectera Attention: Claims Dept. 2811 Lord Baltimore Drive Baltimore, MD 21244-2644 United Behavioral Health's address is: United Healthcare P.O. Box 30555 Salt Lake City, UT 84130-0555

Plan Name, Number and Participants	Plan Type and Type of Administration	Sources of Contributions	Payment of Benefits
2. Group Health Cooperative ("GH") HMO Plan This covers actives only. Plan No. 550 Dependents may be covered; see the Eligibility section.	This provides health, vision, prescription drug and mental health and substance abuse benefits. Insurer administration	Sponsors Participants	Insured. GH insures the benefits through an insurance policy. It also administers the plan, including payment of claims. GH's address is: Group Health Cooperative 1009 Center Parkway Kennewick, WA 99336
3. GH Options Point-of-Service Plan This covers actives. Plan No. 550 Dependents may be covered; see the Eligibility section	This provides health, vision, prescription drug and mental health and substance abuse benefits. Insurer administration	Sponsors Participants	Insured. GH insures the benefits through an insurance policy. It also administers the plan, including payment of claims. See Item 2 for GH's address.
4. CIGNA Dental Assistance or Dental Plus Plan This covers active employees and their dependents, only. Plan No. 550 Dependents may be covered; see	This provides dental care benefits. Contract administration	Dental Assistance: Sponsors Dental Plus: Sponsors Participants	Self-insured by your Employer. CIGNA provides administrative services only. CIGNA's administrative services include claim administration, cost containment, financial, banking and billing administration.

Plan Name, Number and Participants	Plan Type and Type of Administration	Sources of Contributions	Payment of Benefits
the Eligibility section.			Services include payment of claims. CIGNA does not insure any benefits. CIGNA's address is: Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192-2235
5. Willamette Dental of Washington ("WDW") Plan This covers actives. Plan No. 550 Dependents may be covered; see the Eligibility section.	This provides dental care benefits. Insurer administration	Sponsors Participants	Insured. WDW insures the benefits through an insurance policy. It also administers the plan, including payment of claims. WDW's address is: Willamette Dental of Washington (DENKOR) 11241 Slater Avenue N.E. Kirkland, WA 98033-8826
6. CIGNA Basic Life/Accidental Death & Dismemberment ("AD&D") Plan This covers actives.	This provides life and accidental death and dismemberment benefits. Insurer administration	Sponsors Participants	Insured. CIGNA insures the benefits through an insurance policy. It also administers the plan. CIGNA's administrative services include: claim administration,

Plan Name, Number and Participants	Plan Type and Type of Administration	Sources of Contributions	Payment of Benefits
Plan No. 550			cost containment, financial, banking, billing administration and payment of claims. CIGNA's address is: Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192-2235
7. CIGNA Dependent Life Insurance Plan This covers actives. Plan No. 550 Dependents may be covered; see the Eligibility section.	This provides dependent life benefits. Insurer administration	Participants	Insured. CIGNA insures the benefits through an insurance policy. It also administers the plan. CIGNA's administrative services include: claim administration, cost containment, financial banking, billing administration and payment of claims. CIGNA's address is: Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192-2235

Plan Name, Number and Participants	Plan Type and Type of Administration	Sources of Contributions	Payment of Benefits
8. CIGNA Personal Accident Insurance Plan This covers actives. Plan No. 550 Only a dependent spouse may be covered; see the Eligibility section.	This provides accident insurance benefits. Insurer administration	Participants	Insured. CIGNA insures the benefits through an insurance policy. It also administers the plan. CIGNA's administrative services include: claim administration, cost containment, financial banking, billing administration and payment of claims. CIGNA's address is: Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192-2235
9. Short Term Disability Plan This covers actives, except for those represented by the Office and Professional Employees International Union ("OPEIU") Plan No. 550	This provides short term disability benefits. Self-administration and insurer administration.	Sponsors	Partially insured, and partially self-insured by your Employer (see below). After the elimination period, if applicable, and through the 35th day of disability, this benefit is self-insured by your Employer in an amount up to 65% of base salary. Thereafter, CIGNA insures up to 65% of base salary under an insurance policy, except for firefighters

Plan Name, Number and Participants	Plan Type and Type of Administration	Sources of Contributions	Payment of Benefits
			and captains, as described below. CIGNA administers the plan after day 35 and your Employer administers the plan through day 35. CIGNA's administrative services include: claim administration, cost containment, financial banking, billing administration and payment of claims. Firefighters and captains are entitled to 60% of salary replacement benefits up to a maximum of $300 per week. This is insured and administered by CIGNA. Participants who were employed on December 31, 1997 may have salary continuance available in addition to the 65% of salary that is paid by STD. The salary continuance supplements up to 100% of pay. The amount of supplement available is based on hours grandfathered

Plan Name, Number and Participants	Plan Type and Type of Administration	Sources of Contributions	Payment of Benefits
			on December 31, 1997. This can only be used for short-term disability, and is not renewable after use. CIGNA's address is: Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192-2235
10. Long Term Disability Plan This covers actives. Plan No. 550	This provides long term disability benefits. Insurer administration	Sponsors	Partially insured, and partially self-insured by your Employer (see below). CIGNA insures benefits for participants who went on disability prior to 1991 through an insurance policy. The Sponsors self-insure benefits for participants who went on disability in and after 1991. CIGNA also administers the plan. CIGNA's administrative services include: claim administration, cost containment, financial banking, billing administration and payment of

Plan Name, Number and Participants	Plan Type and Type of Administration	Sources of Contributions	Payment of Benefits
			claims. CIGNA's address is: Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192-2235
11. Business Travel Plan This covers actives. Plan No. 550	This provides accident benefits. Insurer administration	Sponsors	Insured. CIGNA insures benefits through an insurance policy. It also administers the plan. CIGNA's administrative services include: claim administration, cost containment, financial banking, billing administration and payment of claims. CIGNA's address is: Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192-2235
12. Group Universal Life (GUL)	This provides life insurance. Contract administration	Participants	Insured. CIGNA insures benefits through an insurance policy. Marsh @Work Solutions, Seabury & Smith, administers the

Plan Name, Number and Participants	Plan Type and Type of Administration	Sources of Contributions	Payment of Benefits
			plan. Their administrative services include: claims administration, cost containment, billing administration and payment of claims. Seabury & Smith's address is: Seabury and Smith 1776 West Lakes Parkway West Des Moines, IA 50398
13. Health Care Flexible Spending Account Plan This covers actives. Plan No. 550	This provides health care reimbursement benefits. Contract administration	Participants	Source of payment is limited solely to employee contributions. United HealthCare administers the plan. Their administrative services include: claim administration, financial banking, billing administration and payment of claims. United's address for FSA is: United Healthcare P.O. Box 981178 El Paso, TX 79998-1178

Plan Name, Number and Participants	Plan Type and Type of Administration	Sources of Contributions	Payment of Benefits
14. Dependent Care Flexible Spending Account Plan This covers actives. Plan No. 550	This provides dependent care reimbursement benefits. Contract administration	Participants	Source of payment is limited solely to employee contributions. United HealthCare administers the plan. Their administrative services include: claim administration, financial banking, billing administration and payment of claims. See Item 13 for UHC's address for FSA's.

Attachment B

SPONSORS CHART

Name of Sponsor	Employer Identification Number	Address
Fluor Hanford, Inc.	33-0691003	P.O. Box 1000, H2-23 Richland, WA 99352
Bechtel Hanford, Inc.	94-3171284	3350 George Washington Way Richland, WA 99352
CH2M HILL Hanford Group, Inc.	91-1733503	P.O. Box 1500 Richland, WA 99352
Protection Technology Hanford	23-2743219	979 Snyder/2505A Richland, WA 99352
Numatec Hanford Corporation	52-1990958	2440 Stevens Center Circle Richland, WA 99352
Johnson Controls, Inc.	39-0380010	P.O. Box 750 Richland, WA 99352
Duratek Federal Services of Hanford, Inc.	36-4066233	P.O. Box 700 Richland, WA 99352
Eberline Services Hanford, Inc.	91-1688187	3350 George Washington Way Richland, WA 99352
Energy Northwest	91-6018049	P.O. Box 968 Richland, WA 99352
CH2M Hill Hanford, Inc	84-1266814	3190 George Washington Way Richland, WA 99352

Attachment C

EMPLOYEE CONTRIBUTIONS TO MEDICAL AND DENTAL PLANS

Effective January 1, 2003[1]

MEDICAL PLANS						
Coverage Level	**United Healthcare PPO**					
	Weekly	**Bi-Weekly**	**Monthly**			
Individual	$9.45	$18.90	$40.95			
Individual + 1 Dependent	$16.52	$33.05	$71.62			
Individual + more than 1 Dependent	$26.76	$53.52	$115.97			
Coverage Level	**Group Health Northwest HMO**			**Options Point-of-Service**		
	Weekly	**Bi-Weekly**	**Monthly**	**Weekly**	**Bi-Weekly**	**Monthly**
Individual	$3.36	$6.72	$14.56	$4.33	$8.67	$18.78
Individual + 1 Dependent	$5.79	$11.59	$25.11	$8.19	$16.39	$35.51
Individual + more than 1 dependent	$10.41	$20.82	$45.11	$13.44	$26.88	$58.23

[1] The amounts of these contributions may be increased or decreased at any time by the Trust and the Sponsors.

DENTAL PLANS			
Plan Name	**Employee Contributions (Single Rate for Employee and Eligible Dependents)**		
	Weekly	**Bi-Weekly**	**Monthly**
Dental Assistance	No Cost	No Cost	No Cost
Dental Plus	$2.40	$4.80	$10.40
Willamette Dental of Washington, Inc.	$2.54	$5.08	$11.00

Attachment D

CHANGE OF ELIGIBILITY

Benefit Plan	If you are laid off – (Reduction of Force – ROF)	If you quit (Voluntary Termination)	If you retire	If you are on disability	If you die
Medical/Vision					
United HealthCare Options PPO Plan, Group Health HMO Plan, and Group Health Options Point of Service Plan	Can continue medical/vision coverage for self and dependents for one year following layoff. In certain circumstances coverage may continue beyond one year until/unless eligible for coverage by another employer or through spouse, as follows: Year 1: Same cost as paid by active employees for medical; pay full cost of vision	Can continue your personal/dependent medical/vision coverage for up to 18 months under provisions of COBRA.	Coverage ends but you may be eligible for retiree medical under one of the plans offered to retirees. Your cost will be based on the structure in place at time of retirement and is subject to change.	Medical/vision coverage continues for you and eligible dependents at the same rate as active employees as long as you continue to qualify for disability and you pay the required premium.	Medical/vision can continue for dependents for up to one year. If you are early retirement eligible (age 55 with 10 vesting years) at the time of your death, dependents can continue medical coverage under retiree provisions.

Benefit Plan	If you are laid off – (Reduction of Force – ROF)	If you quit (Voluntary Termination)	If you retire	If you are on disability	If you die
	coverage. Year 2: 50% of COBRA rate for medical, if eligible; full cost of vision, if eligible. Year 3: 100% of COBRA rate for medical and vision, if eligible.				
Dental					
CIGNA Dental Assistance or Dental Plus Plan, and Willamette Dental of Washington, Inc. Plan	Can continue for self and dependents: Year 1: Full COBRA rate, if eligible; Year 2: Full COBRA rate, if eligible; Year 3: Full COBRA rate, if	Can continue under provisions of COBRA for up to 18 months by full COBRA rate.	Company-sponsored dental plans are not offered to retirees. Retiree-paid dental coverage is offered by Willamette Dental of Washington.	Dental coverage can continue for you and eligible dependents at the same rate as active employees for one year as long as you continue to qualify for disability and you pay the required premium.	Dependent dental coverage continues at no cost for one month, with additional eligibility for COBRA for 11 or 35 additional months, depending on circumstances.

Benefit Plan	If you are laid off – (Reduction of Force – ROF)	If you quit (Voluntary Termination)	If you retire	If you are on disability	If you die
	eligible.				
Short Term Disability Coverage					
Short Term Disability Plan	Coverage ends 31 days after your last day worked.	Coverage ends on your last day worked.	Coverage ends on your last day worked.	NA	Coverage not applicable
Long Term Disability Coverage					
Long Term Disability Plan	Coverage can be continued for up to one year by paying the full cost.	Coverage ends on last day worked.	Coverage ends on last day worked.	NA	NA
Basic Life/Accidental Death and Dismemberment Insurance (AD&D)					
Basic Life/Accidental Death & Dismemberment Plan	Basic Life/AD&D coverage automatically continues for 31 days after your last day worked. Coverage can be extended up to one year after layoff by paying required premium.	Basic Life/AD&D coverage automatically ends 31 days after your last day worked.	Coverage ends. You may be eligible to continue all or part of the Basic Life/AD&D coverage under a separate plan offered to retirees.	Coverage continues. Company pays required cost while on LTD.	NA

Benefit Plan	If you are laid off – (Reduction of Force – ROF)	If you quit (Voluntary Termination)	If you retire	If you are on disability	If you die
	Conversion to private coverage is offered by the insurance company.				
Dependent Life Insurance					
Dependent Life Insurance Plan	You can continue, for up to one year, the coverage you have at the time of layoff by paying the required premiums in advance.	Coverage ceases as of the last day worked.	Coverage ends. You may be eligible to continue the Dependent Life for a period of time under a separate plan offered to retirees.	N/A (Ceases).	Dependent Life Insurance Coverage ceases.
Personal Accident Insurance (PAI)					
Personal Accident Insurance Plan	You can continue, for up to one year, the PAI coverage you have at the time of layoff by paying the required premium in advance.	Coverage ceases as of the last day worked.	Coverage ceases as of the last day worked.	Coverage can continue for one year provided you pay the required premiums in advance.	Coverage ceases.

Group Universal Life (GUL)	You can continue coverage by paying premiums to the administrator.	You can continue coverage by paying premiums to the administrator.	You can continue coverage by paying premiums to the administrator.	You can continue coverage by paying premiums to the administrator.	Your coverage ceases. Spouse coverage, if any, can be continued on a self-pay basis.
Business Travel Plan	Coverage ceases as of the last day worked.	Coverage ceases as of the last day worked.	Coverage ceases as of the last day worked.	Coverage ceases as of the last day worked.	Coverage ceases.
Flexible Spending Accounts	You may qualify for continued coverage under certain circumstances. You will receive a notice at the applicable time if these circumstances apply in your case.	Same as ROF	Same as ROF.	Same as ROF.	N/A Contributions cease. One can request reimbursement only for qualifying services that were incurred while employed. Funds remaining in the FSA accounts are forfeited.